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Dear President Obama, August 27, 2009

The national debate on health care has deteriorated into a shouting match among special interests. And, by definition, no one of these special interests is shouting on behalf of the American people as a whole.

The United Kingdom has had a system in place for 50 years that both provides access for all and spends roughly one-half per-capita of what we do. They also ranked 18th in the latest World Health Organization's (WHO) ranking of the overall effectiveness of national health systems. We came in at 37th just behind Costa Rica and just ahead of Slovenia and Cuba. While the WHO rankings have their limitations, it seems clear that we are at best at parity with other leading nations. Every other developed nation also placed well ahead of us and all spend two-thirds or less per capita than we do.

The reason is that our insurance system was not designed to provide access for all. In fact it wasn't designed at all. It just grew like Topsy as programs were added piece-meal to meet the needs of various constituencies and both public and private insurance bureaucracies were created to administer them.

We would do it very differently if we really set out from scratch to design a system to meet our goal of equal access. Obviously we aren't starting from scratch and we will need to execute a difficult transition to a new system. But it would be nice to know what the essential elements of a well-designed system would look like.

Most importantly it would give you a better basis on which to shape the political debate and convince the American people not only of the need for change but also of its magnitude and the direction it should take.

What might such a system look like?

The Meaning of Universal Access

Implicit in the goal of universal access is that the guaranteed access will be the same for each individual. Nothing else is defensible given the nature of our democracy. We can't say we'll guarantee a higher level of care only for tall people, or black people, or rich people, or poor people or senators or sanitation workers. Once the government commits to equal access it is committing to equal access for everybody.

Also implicit in this objective is the idea that the guarantor, the government, will have to subsidize those people who can't afford to pay for the care. (The top two quintiles of households account for roughly 75% of national income and the bottom two only 10%.) The high cost of care and this highly skewed income distribution among our families' means that guaranteeing equal access will clearly require substantial government subsidies for a very significant portion of the population. One

way or the other the higher income groups will see increased taxes unless you can substantially reduce costs. On the other hand, if we can match the cost performance of the United Kingdom, or even that of the other developed nations, the high-income groups could well see a reduction in their total costs (health care + taxes) as well.

Not surprisingly, **a specific definition of what is to be included in the guaranteed access will be necessary to avoid bankrupting the government.** If the what of guaranteed access is left undefined and open-ended, the combination of what technology will make possible and what the population will demand will make it increasingly difficult to make ends meet.

And, finally, guaranteed equal access to health care doesn't mean that those who desire access to higher levels of care and can afford it should be denied the right to pursue it at their own expense. That is the real meaning of freedom of choice in America as far as health care is concerned. Moreover these personal decisions should not be the concern of government. The goal of the government should be to create a system that can provide a guaranteed level of access sufficient to render the demand for additional care insignificant and limited to a relatively small percentage of the population.

The key design challenge then becomes: **"How do we minimize the cost to the government of providing the guaranteed level of access so that the resultant care covers the great majority of the needs of the population."**

MINIMIZING COST

Rightsizing the Insurance Industry

Any experienced executive will tell you that the easiest way to cut costs is to stop performing functions that are not necessary. We now support an enormous, purely administrative insurance and reimbursement infrastructure that segments markets in ways that create an extraordinary range of possible access options for the insured. This is, of course, the diametrical opposite of a system designed to guarantee equal access to all. This infrastructure is very expensive and yet, in the end, has very little effect on the care actually delivered to any patient. Our hospitals are legally required to provide necessary care so they provide it to the uninsured with the emergency room serving as the entry to the system and they write it off. Similarly, the choice of policy that one makes rarely influences the care they receive. Choices such as deductibles, co-pays and other bells and whistles affect only how and if the bills get paid but in the end the patient gets more or less the same care and the uncovered cost is written off by the provider. In other words substantial costs are generated by the both the private and public insurance systems but little or no value is added.

Committing to guarantee equal access to everyone creates an enormous opportunity to reduce cost in the insurance and reimbursement infrastructure because the decisions about who is entitled to what care and how the providers will be paid become trivial. What care is defined by defining the specifics of the guaranteed access. **Everybody** is entitled to it. The only criterion becomes "Is the care necessary?" And since the government is providing the guarantees, all the bills get paid. In other words there is no need

for an insurance/reimbursement industry or any of the administrative entities it requires in providers and the various middlemen that generate significant costs and deliver no health care. All the costs of product differentiation and of marketing a highly differentiated product line and the extraordinary costs associated with negotiating case-by-case reimbursement decisions disappear. Moreover the nagging problems of pre-existing conditions and portability also disappear.

The fact that insurance, either private or public, plays no role in the United Kingdom's National Health Service is a major reason it enjoys much lower per capita costs. The private insurance segment, which offers certain alternatives, accounts for only about 10% of the care.

A study published in the authoritative New England Journal of Medicine in 2003 compared administrative costs in the United State to those in Canada. The study estimated the total cost of health care administration in the United States to be 30% of total cost (or about $700 Billion in today's expenditures) and 15% in Canada. Thus, we could save $350 Billion if we could duplicate Canada's experience. In fact our significantly larger scale could allow us to take out as much as $500 Billion.

The notion of designing our insurance and reimbursement systems to be in tune with our national goals is not an idea that will be welcomed by the insurance industry, which becomes largely redundant as does much of the bureaucracy that has had to be created in the providers and other middlemen to deal with our enormously complicated reimbursement systems. Eliminating these bureaucracies will require serious downsizing of the administrative infrastructures of both the private and public insurers as well providers and will need to be carefully phased in over time. But the book is worth the candle. **This bureaucratic downsizing has to be the primary objective of any serious health care reform.**

The argument that this "one size fits all " guaranteed access will lead to "socialized medicine" is fallacious. In the first place **it is not " one size fits all" medical care**. It is a guarantee that every individual will get the care that she or he needs. Which I believe is your goal. And second, as I explain later in this note, it need not affect the way the hospitals, physicians and other professional deliver care. In fact the reduction in administrative load should free up capacity for physicians.

One could probably call it "socialized insurance" I suppose. But that is exactly what guaranteeing equal access means. The Government will take the risk. The traditional tailored insurance policy is no longer necessary or appropriate and the process of funding the system and reimbursing the providers can be enormously simplified, as I will be explaining shortly.

Controlling Overutilization

The recent article by Dr. Atul Gawande in the ***New Yorker*** highlights a second opportunity for bringing costs under control – ensuring that the care actually delivered is necessary. Dr. Gawande eloquently illustrates what the Dartmouth studies have shown for years. There are vast differences in the amount of care delivered in various regions of the country but no discernible difference in outcomes. Regrettably it appears that our enormously complicated and expensive reimbursement systems have utterly failed in controlling overutilization. As Dr. Gawande points out, this overutilization is at least in

part driven by the desire on the part of some segments of the medical profession to bend their behavior in the direction of maximizing their personal profit as opposed to delivering quality care with careful stewardship of scarce health care resources.

This behavior is, in turn, importantly enabled by a sense of entitlement on the part of patients and a resulting desire to make use of every test, drug or procedure that is covered with little regard as to real need for the treatment in question. This sense of entitlement is largely a result of providing tax preferences to employees covered by Employer Sponsored Insurance. These tax preferences allow the most influential segments of the population – those who are the best educated and have steady high paying jobs – to pay for their coverage with pre-tax dollars. This has led to a sense of entitlement to "free" (employer provided) health care on the part of this segment of the population. Their demands reinforce the profit-oriented behavior of physicians. It also feeds the longer-term demand for including ever more expensive and, in many cases, marginally effective modalities in the coverage. This is another very slippery cultural slope and our health care costs are spiraling out of control as we slide down.

These are festering cultural problems that undermine the notion of the physician as a professional and cast him more as a businessman intent on maximizing profit. They also encourage patients to demand unnecessary products and services. Defensive medicine in the face of malpractice suits exacerbates the problem of overutilization. It's a slippery cultural slope that both patients and physicians can easily be tempted to try to navigate but the unintended consequences are already creating tremendous financial strains on the system.

Moreover the foregone tax revenues effectively deliver government health care subsidies approaching **$300 Billion** to the segment of our population that least requires them.

In other words, Mr. President, there are two straightforward directions you can take to streamline administration of the health care system and bring costs under control without affecting the quality of care one iota. These two actions alone would bring our total per capita costs in line with those of other developed nations.

FINANCING GUARANTEED ACCESS

The first step in defining a guaranteed access system is specifying the level of access. The simplest approach would be to simply take an existing level of coverage (say, for example, what we provide members of Congress), scaling it down (or up) as deemed appropriate and adjusting it over time as more experience with the benefit/cost dynamic is gained. It's a classic case of where being approximately right is good enough and much preferable to a contentious and fruitless search for a more precise (but unknowable) answer. Responsibility for making these decisions would be placed in a quasi-public National Health Security Agency (NHSA) designed in a manner similar to the Federal Reserve, i.e. insulated from the political process. Tax tables would then be revised to include sufficient revenue to fund the entire program. The economies created would, at a minimum, compensate for the costs of providing increased access and would very likely reduce the total burden of income taxes and health care costs on most taxpayers. The costs of health care could be separately identified for each individual

and the resulting transparency would enlighten the debate as to what level of access the country could afford to guarantee and would also provide necessary information for their decisions to the NHSA.

Lower income citizens would love the system because it would eliminate a major source of worry for them.

Higher income citizens would be pleased because their total costs for health care and income taxes would be reduced.

Employers would embrace this approach enthusiastically because it would eliminate an entire function (the part of Human Resources that managed health insurance) and hand the responsibility for controlling costs to the National Health Security Agency that would have the information and authority to do so. This would be a boon to American competitiveness.

REIMBURSING THE PROVIDERS

The NHSA would define a Rate Card fee for each element of care and set reimbursement rates for each element. This could be a Medicare-like (DRG) system with one exception: the rates would need to be sufficient to keep the hospitals and physicians solvent without the enormous cross-subsidies now provided by the private insurers. **Considering the Medicare and Medicaid experience of gross under-reimbursement this will be major source of concern for providers and will need to be addressed head-on.**

Individual physicians who earned a reputation for superior care would be able to charge premiums above the Rate Card for patients prepared to pay it. Similarly with hospitals and other providers. This is probably the most straightforward way to "pay for performance" i.e. through market forces.

Individuals or families desiring additional coverage or services would be free to do so at their own expense and freedom of choice would be preserved. The government would play no role in this arena beyond certifying the safety and efficacy of the modalities (drugs, procedures) involved.

The roles of physicians and hospitals in the system would be largely unchanged in the short run except that their administrative burdens would be greatly reduced and they would be assured of payment for the services they delivered.

The NHSA could also be charged with facilitating positive change in the delivery system and attacking the life-style issues that plague the country and generate significant unnecessary cost.

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Your effort to reform health care is running into predicable difficulty as special interest groups scramble to protect their turf. This is not surprising since it comes primarily from special interest groups that have a vested interest in preserving two of the most costly and counterproductive aspects of our current

system, namely complex and unnecessary product differentiation (the raison-d'être for the insurance industry) and the tax preferences for Employer Sponsored Insurance.

You need to seize the initiative, clarify your commitment to guaranteed access for all and, most importantly, what it really means. You will have to take the insurance industry head-on and move as rapidly as possible toward a single payer system. The piecemeal approach of trying to patch our current system to achieve a dramatically different objective is bound to founder in a war of attrition with the special interest groups. A so-called "politically acceptable" solution is very unlikely to solve the problem. You need to change what's considered "politically acceptable" by reaching out to the American people and bypassing the special interests.

If you fail to get a bill passed, you will lose credibility and the system will eventually founder on the shoals of unnecessary costs. If you settle simply for expanded coverage you will have fallen short and the system will founder of its own weight sooner. The only way to win is to go for real reform and that means taking the insurance companies head on. You have the skills to both educate and gain the support of the electorate and to get the job done but if you hesitate to seize the initiative from the special interests you will lose the mandate.

If you persevere, the American people will respond to the logic of the need for dramatic change and you will achieve the mandate you need, the change that is necessary and the legacy you deserve.

Fred Gluck August 27, 2009